

AO 440 (Rev 1/80) Summons in a Civil Action

United States District Court

FIRST

DISTRICT OF MASSACHUSETTS

GERTRUDE GOROD

SUMMONS IN A CIVIL ACTION

V.

CASE NUMBER:

MASSACHUSETTS GENERAL HOSPITAL
DR. WILLIAM BINDER
JAMES W. MCCARTHY
ERIK NORENIKA
SUSAN WARCHAL
DIPLOMAT
CARUSO MUSIC
LAWRENCE CARUSO,
TO: (Name and Address of Defendant)

05 - 10842 WGY

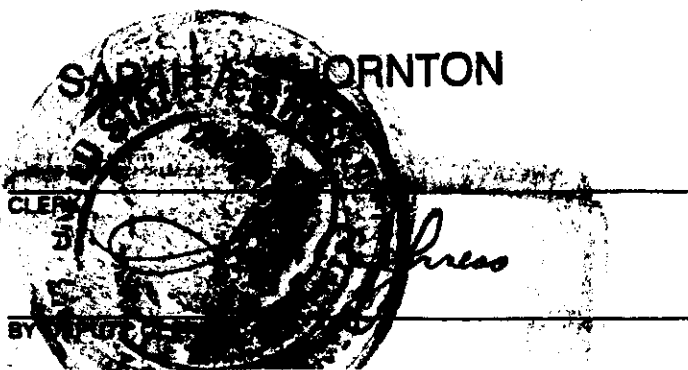
MASSACHUSETTS GENERAL HOSPITAL
c/o DR. WILLIAM BINDER
Emergency Medicine
55 FRUIT STREET
BOSTON, MA 02114

YOU ARE HEREBY SUMMONED and required to file with the Clerk of this Court and serve upon

PLAINTIFF'S ATTORNEY (name and address)

Gertrude Gorod
P.O. Box 856
Everett, Ma 02149

an answer to the complaint which is herewith served upon you, within Twenty days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.



DATE

4-26-05

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RETURN OF SERVICE

Service of the Summons and Complaint was made by mail	DATE
NAME OF SERVER (PRINT) UNITED STATES POSTAL SERVICE	TITLE

Check one box below to indicate appropriate method of service

- ☐ Served personally upon the defendant. Place where served: _____
- ☐ Left copies thereof at the defendant's dwelling house or usual place of abode with a person of suitable age and discretion then residing therein.
Name of person with whom the summons and complaint were left: _____
- ☐ Returned unexecuted: _____
- ☒ Other (specify): CERTIFIED MAIL SEE: BELOW

STATEMENT OF SERVICE FEES

TRAVEL	SERVICES	TOTAL
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DECLARATION OF SERVER

I declare under penalty of perjury under the laws of the United States of America that the foregoing information contained in the Return of Service and Statement of Service Fees is true and correct.

Executed on _____ Date _____ Signature of Server _____

Address of Server _____

7004 2510 0004 0155 5957

Complete items 1, 2, and 3. Attach complete item 4 if Restricted Delivery is desired.
Print your name and address on the reverse so that we can return the card to you.
Attach this card to the back of the mailpiece, or on the front if space permits.

Article Addressed to:

Mass General Hospital
30 Dr. William Binder
55 Fruit Street
Boston, Ma 02114

1. Signature <i>[Signature]</i>		<input type="checkbox"/> Agent <input type="checkbox"/> Addressee
2. Received by (Print Name)		3. Date of Delivery
4. Is delivery address different from item 1? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, enter delivery address below:		
5. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Registered Mail <input type="checkbox"/> Registered Mail <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> G.O.D.		
6. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes <input type="checkbox"/> No		

APR 27 2005

USPS

Postage	Certified Fee	Return Receipt Fee (Endorsement Required)	Restricted Delivery Fee (Endorsement Required)
\$ 0.60	2.30	1.75	
Total Postage & Fees	\$ 4.65		

OFFICIAL USE

U.S. Postal Service
CERTIFIED MAIL RECEIPT
Domestic Mail Only. No Insurance Cover and Restricted Delivery.

Article Number:

7004 2510 0004 0155 5957